DCH/LPA-020 (05/04)

Michigan Department of Community Health
Task Force on Physician's Assistants
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

PHYSICIAN'S ASSISTANTS LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Task Force on Physician's Assistants. Questions regarding your application can be directed to the Task Force on Physician's Assistants at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time.

GENERAL INSTRUCTIONS FOR LICENSURE

An applicant for licensure as a physician's assistant must be a graduate of a program for the training of physician's assistants approved by the task force or be a licensed, certified, registered, approved, or other legally recognized physician's assistant in another state with qualifications substantially equivalent to those established by the Michigan Task Force.

1. Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Failure to correctly complete the application in its entirety may delay the processing of your application.

2. Your check or money order drawn on a U.S. Financial Institution and made payable to the **STATE OF MICHIGAN** must accompany the application. Applications received without a fee will be returned to you and will not be considered by the Task Force until the proper fee has been received. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

3. Authorize your Physician's Assistant Educational Program to forward a final, official transcript directly to this office. The transcript must show the degree/certificate earned and date the degree was conferred.

4. If you are applying for a temporary license, you must have your school send us either a) a final, official transcript of your PA degree or b) an official letter of good standing from your Dean or Program Director that includes the date you completed your PA program. A temporary license is valid for not more than 18 months, is non-renewable, and will be revoked upon notification that the applicant has failed the examination.

5. You must submit a written request to NCCPA to have your PANCE Examination scores sent directly to the Board office. The written request must include your full name, social security number and birthdate. You may submit your written request by fax (678) 417-8135, e-mail suef@nccpa.net or by mail to NCCPA, 12000 Findley Rd, Ste 200, Duluth GA 30097.

6. Send the Verification of Licensure or Registration form to any state where you are currently or have ever held a permanent physician's assistant license. The form must be submitted directly to the Board office. The attached Verification of Licensure Form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

7. If you were originally licensed in a state that used a licensing examination other than the PANCE examination, please complete part I of the enclosed Certification of Licensure by Endorsement form and forward the form to that state. The form must be submitted directly to the Board office. You may wish to check with the other state as a fee is usually charged for this service.

8. For information regarding the NCCPA Examination, please contact:

The National Commission on Certification of Physician's Assistants, Inc.
12000 Findley Road
Suite 200
Duluth, GA 30097
(678) 417-8100
www.nccpa.net

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Michigan Task Force on Physician's Assistants in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Michigan Task Force on Physician's Assistants in writing to request a refund.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS, SUBSEQUENT RENEWALS ARE VALID FOR A TWO-YEAR PERIOD.

DCH/LPA-010 (05/04)

Michigan Department of Community Health
Task Force on Physician's Assistants
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR LICENSURE AS A PHYSICIAN'S ASSISTANT

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

- ☐ **Physician's Assistant License by Examination Fee: $90.00 71-5601-01**
- ☐ **Physician's Assistant License by Endorsement Fee: $90.00 71-5601-09 (Must Currently be Licensed in Another State)**
- ☐ **Physician's Assistant License by Examination and Temporary License Fee : $125.00 71-5601-401**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Have you ever held a health professional license in Michigan?

☐ No ☐ Yes

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. **Have you ever been convicted of a felony?**	☐ **Yes**	☐ **No**
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?**	☐ **Yes**	☐ **No**
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?**	☐ **Yes**	☐ **No**
4. **Have you been treated for substance abuse in the past 2 years?**	☐ **Yes**	☐ **No**
5. **Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?**	☐ **Yes**	☐ **No**
6. **Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?**	☐ **Yes**	☐ **No**
7. **Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?**	☐ **Yes**	☐ **No**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Do you hold or have you ever held a physician's assistant license in any state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License/Registration Number	Date of Issue	How Obtained (Endorsement or examination)

10. Have you passed the NCCPA PANCE examination? ☐ Yes ☐ No

Provide a complete chronological record of your PA education.
Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance From	To	Degree

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Task Force on Physician's Assistants
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF LICENSURE BY ENDORSEMENT

Authority: Public Act 368 of 1978, as amended
If this form is not complete, a license will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the state licensing agency in the state from which you are endorsing for completion of Section II. This certification must be submitted directly to the Michigan Task Force on Physician's Assistants by the state licensing agency where you are currently licensed.

First Name	Middle Name	Last Name
Street Address		
City		
State		ZIP Code
Social Security Number		Date of Birth
Type of License	Michigan Permanent I.D. Number and Expiration Date	

Professional School Attended	
Street Address	
City	
State	ZIP Code

Signature of Applicant	Date

Applicant: Upon completion of section I, send this form to the licensing agency in the state from which you are endorsing for completion of Section II.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

SECTION II IS TO BE COMPLETED BY THE LICENSING AGENCY IN THE STATE FROM WHICH THE APPLICANT IS ENDORSING.

SECTION II - CERTIFICATION

Please complete the following information. Return this completed certification directly to the Michigan Task Force on Physician's Assistants at the address shown on the reverse side of this form.

Applicant's Name as Licensed	
License Number	Date Issued
License Status ☐ Current ☐ Lapsed ☐ Inactive	Expiration Date

1. Has the applicant incurred any disciplinary proceedings in your state? (Please attach **certified** copies of any actions.) ☐ YES ☐ NO
2. Are disciplinary proceedings pending? ☐ YES ☐ NO
3. Has the applicant's license ever been limited, denied, surrendered, suspended or revoked? (Please attach **certified** copies of any actions.) ☐ YES ☐ NO

EXAMINATION INFORMATION

Licensure requirements in effect at the time applicant was licensed in your state:

☐ Degree
☐ Accredited School
☐ Licensure Exam - Please Specify ☐ National Board ☐ State Constructed
☐ Other: Please Specify _____

Dates of Examination:

SCORE MEANS A NUMBER, PERCENT OR PASS/FAIL.
PLEASE PROVIDE AS MUCH INFORMATION REGARDING THIS EXAMINATION AS POSSIBLE

EXAMINATION SUBJECT	APPLICANT SCORE	EXAMINATION SUBJECT	APPLICANT SCORE

Please describe the passing score that was in effect at the time the above examination was taken:

Please describe the criteria used to determine the passing score.

:

_____ _____
Authorized Signature Date of Signature

_____
Print or Type Name

SEAL

_____
State Board

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.